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COMMENTARY

Psychosocial, HIV, and Health Care Management Issues Impacting Transgender Individuals

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Caitlyn Jenner's announcement of her transition from male to female has focused public attention on the transgender (TG) community. Ms. Jenner's wealth and largely receptive colleagues and family have afforded her a privilege unknown in the lives of many TG people. TG people are more likely to be denigrated and stereotyped as social deviants rather than lauded for their courage, as Ms. Jenner was when she received the Arthur Ashe Courage Award at the 2015 Excellence in Sports Performance Yearly Awards. TG individuals often feel unaccepted, and in some cases, reviled in workplaces, health care settings, the judicial system, public accommodations, and family relationships.

Indeed, TG individuals often experience a wide range of stressors that can negatively impinge on their mental health, quality of life, and most aspects of their everyday lives (see Figure 1). According to the 2011 National Transgender Discrimination Survey, nearly two thirds of TG, or gender nonconforming, respondents reported serious acts of discrimination; almost half had been fired, not hired, or denied a promotion as a result of their TG status; and one fifth had been homeless at some point in their lives.

The high frequency of economic hardship, unemployment, and homelessness among the TG community can lead some individuals to engage in high-risk activities (e.g., sex work) simply to survive. Not surprisingly, TG women, and especially TG women who have sex with men, carry an extraordinarily heavy burden with respect to HIV. Historically, however, TG individuals have received little attention in the global response to prevent HIV infection.

According to a review conducted by Jan Redfern and Bill Sinclair, the ability of TG individuals to access medical services is hampered by pervasive discrimination and the social stigma associated with being TG. Indeed, with respect to health care in general, TG persons continue to represent a generally underserved and ill-served population, particularly outside of major metropolitan areas. A number of university medical centers, community hospitals, and health centers have begun to recognize the health inequities experienced by TG people and the need to foster gender-affirming medical care. In response, these institutions have begun to open multidisciplinary, holistic clinics to serve the lesbian, gay, bisexual, and TG (LGBT) community as a whole or TG individuals specifically. Comprehensive TG-specific health care services can also help to address the burgeoning prevalence of HIV among TG people.

This article reviews the varied process of transitioning and the psychosocial and quality-of-life benefits and outcomes of gender-affirmation therapeutic interventions, examines the barriers that TG persons face in accessing health care, and describes the authors' experiences in improving access to medical services by launching a TG health care clinic and a service provider collaborative. It concludes with a summary of the burgeoning prevalence of HIV among TG people and the associated psychosocial effects.

Heterogeneous Process of Transitioning

Some, but by no means all, TG people may experience marked discomfort or distress with their sex assigned at birth and consistently and insistently self-identify and express themselves as the opposite sex. This clinically significant distress may be assuaged and a sense of completeness and well-being may ensue when such individuals begin to openly express their gender identity. For some, this open expression of their gender identity includes making a transition—that is, to change their physical, social, and legal characteristics to the gender opposite that of their sex assigned at birth (*biologic sex*). The transition process may be accompanied by treatment of TG individuals with feminizing or masculinizing hormones to help transform their physical appearance to match their gender identity and, in some cases, by gender-affirmation surgery. The American Psychiatric Association, the American Medical Association, and the Endocrine Society, among many others, recognize the benefits and necessity of gender transition treatments for appropriately selected TG individuals.

The process of transition from male to female (*TG woman* or *trans woman*) or female to male (*TG man* or *trans man*) is often an intricate journey that varies enormously in scope and time

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frame from individual to individual. For some TG women, for example, this may range from presenting as a female by changing hair styles, using makeup, and wearing feminine clothing to more extensive physical changes associated with estrogen therapy, breast implantation, genital reconstruction, and feminizing facial surgeries. Treatment of TG patients should be individualized because not all patients will chose or require hormone therapy or surgery.

TG persons represent an underserved and ill-served population

Mental health professionals play a critical role in helping TG patients attain a deeper understanding of themselves and helping them reach an equilibrium point in terms of their body and gender identity and expression. A primary goal for the mental health care provider is to assist TG individuals in making critical decisions regarding the extent, timing, and process (if any) of a gender role transition. Individualized counseling can also help TG people address any adverse effects of gender dysphoria on mental health, diminish internalized transphobia, bolster social and peer support, enhance body image, and increase resilience.

Psychosocial and Quality of Life Benefits of Transitioning

Much of the evidence of therapeutic benefit in treating TG individuals with respect to psychosocial outcomes and quality of life has focused on individuals who have transitioned and undergone hormone therapy, with or without genital surgery, aimed at making his or her body as congruent with the opposite sex as possible. One of the most comprehensive outcome studies, conducted by Mayo Clinic physician Mohammad Hassan Murad and colleagues, involved a meta-analysis of 28 reports (average duration of follow-up of 6 years) and a total of 1,093 male-to-female and 801 female-to-male TG individuals. Participants had been diagnosed with gender identity disorder and were in the process of undergoing sex reassignment that included hormone therapy. After combining the results across selected studies, Murad and colleagues found that a majority (approximately 72% to 80%) of patients who underwent hormone therapy and sex reassignment experienced subjective improvements in gender dysphoria, quality of life, psychological symptoms, and sexual functioning. There was, however, heterogeneity in outcome from study to study, with several showing deterioration in some of these measures.

The psychological functioning of TG individuals after reassignment was generally comparable to the psychological functioning reported for the non-TG population. Their finding was also consistent with the results of a 2014 study by Annelou de Vries and colleagues that evaluated TG adolescents before and after puberty suppression, cross-sex hormone therapy, and gender reassignment. These young adults (mean age at enrollment of 13.6 years) showed improvements in subjective and objective well-being after gender reassignment surgery to levels comparable to that seen in same-age peers.

From an evidence-based practice perspective, meta-analyses of multiple randomized controlled trials have traditionally provided one of the most robust categories of evidence for clinical decision making. In the case of the Murad meta-analysis, however, the authors considered the collective evidence to be of low quality. Most of the individual studies included in the analysis lacked control groups, were not randomized, and relied mainly on patient self-reporting with respect to therapeutic interventions received.

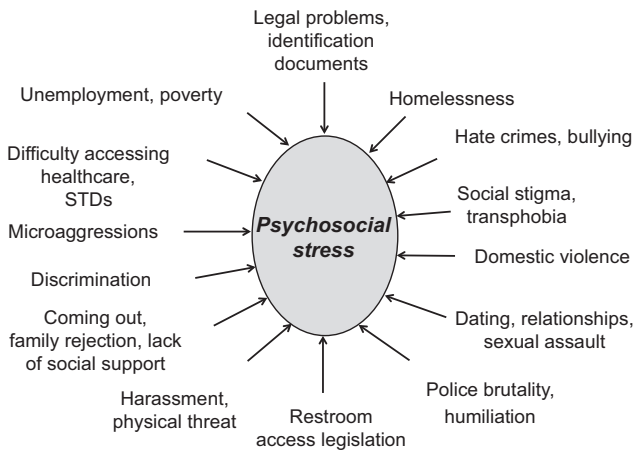

Figure 1. Overview of potential sources of psychosocial stress in TG individuals.

Long-Term Outcomes of Gender-Affirmation Therapeutic Interventions

Although many of the studies analyzed by Murad and colleagues revealed psychiatric or psychological improvement after hormone therapy with or without surgery, much remains to be learned about the long-term ramifications of gender-affirmation therapeutic interventions. One valuable approach to overcome limited follow-up time and high dropout rates seen in many of the prior outcomes studies is to utilize the national registers of Scandinavian countries.

One such population cohort study by psychiatrist and clinical sexologist Cecilia Dhejne and colleagues evaluated psychiatric morbidity, overall mortality, and psychosocial integration in 324 sex-reassigned individuals (191 male-to-female, 133 female-to-male) over a 30-year period (1973–2003) using the Swedish national registers. The researchers found that, after gender-affirmation surgery, TG men and women had a considerably higher rate of overall mortality (adjusted hazard ratio [aHR] 2.8), death from suicide (aHR 19.1), suicide attempts (aHR 4.9), and psychiatric inpatient care (aHR 2.8) compared to an age-matched healthy control population of the same sex at birth. However, subgroup analysis revealed that risks of any death, psychiatric hospitalizations and suicide attempts were lower during follow up when TG individuals underwent reassignment from 1989 to 2003 compared with

reassignment during earlier years (1973 to 1988), a finding perhaps reflective of society's changing attitudes and improved TG health care in recent decades. These results led the authors to conclude that sex reassignment alone "may not suffice as treatment for transsexualism," even though it alleviates gender dysphoria, and that sustained mental health follow-up is appropriate.

Approximately 20% of TG individuals have been homeless at some time in their lives

The Swedish study also raises important questions regarding the underlying factors that contribute to the alarmingly high rates of suicide and psychiatric morbidity among TG people long after transitioning. Are the contributing factors related to internalized feelings such as shame, guilt, or self-hatred that persist regardless of therapy? Are they more related to the implicit and explicit biases and social forces that repress or oppose gender nonconformity and thereby create distress and suffering? Are they the algebraic sum of many disparate elements?

Of particular relevance in this regard is a study published in 2015 by Amaya Perez-Brumer and colleagues. The investigators evaluated individual- and structural-level risk factors for suicide attempts among 1,229 TG adults. The study showed that the odds of attempted suicide were linked to internalized transphobia, lower educational levels, and racial/ethnic minority status. Fewer lifetime suicide attempts were associated with lower levels of *structural stigma*, a term used to describe a composite of societal-level circumstances, institutional rules, policies and procedures, and societal norms that affect the rights, opportunities, and well-being of a marginalized group (in this case, TG individuals). Other studies have shown suicide ideation and suicide attempts may also be linked to depression, history of substance abuse treatment, gender-based discrimination and victimization, social exclusion, lack of access to medical transition, and absence of identification documents with an appropriate gender marker.

Access to TG Health Care

A pressing need exists for improved access to mental health, medical, and social services, and continued follow-up of TG individuals after completing their transition. Further, the social stigma and fear of discrimination experienced by TG people may negatively affect health-seeking behaviors and willingness to talk candidly with health care providers about gender identity. This, in turn, may potentially lead to inappropriate or unsatisfactory care, including missed opportunities to individualize screenings based on anatomy present and to assess risk for sexually transmitted diseases. Postponing health visits for fear of discrimination or embarrassment can result in individuals seeking emergency treatment only and means that preventable illnesses are not addressed, complications worsen, and costs increase.

As discussed by Taylor Cruz in 2014, stigma and discrimination faced by TG and gender-nonconforming people in the health care setting may play out in several ways. These include: (a) directly by providers declining to deliver care or making TG people feel uncomfortable when pursuing care, (b) structurally by a lack of providers or institutions with the expertise and willingness to provide care, and (c) internally by negative feelings and beliefs TG individuals have toward themselves.

One underappreciated form of discrimination that many TG individuals experience on a daily basis is *microaggression*. In contrast to hate crimes or overt acts of discrimination and bigotry, microaggressions represent brief and subtle antagonistic, derogatory, or negative snubs toward TG people. In many cases, the persons responsible for microaggressions may be unaware that they are engaging in such activities. These microaggressions may be interpersonal in nature or may occur at the institutional or community level. According to counseling psychologist Kevin Nadal and colleagues, TG microaggressions can include a number of broad areas (e.g., use of transphobic and/or incorrect gendered terminology; discomfort with or disapproval of the TG experience; exoticization; endorsement of gender normative and binary culture or behaviors; assumption of sexual pathology or abnormality; denial of the existence of transphobia; denial of personal body privacy).

As mentioned, health care for TG individuals is complex, requires coordination of multiple specialties and procedures, and ideally should involve a lifetime of follow-up given the frequent associations with mental health issues, substance abuse, and risk of acquiring sexually transmitted infections. There are certainly advocates for the mainstreaming of health care for TG individuals, but many practitioners are uninformed about TG health issues and feel inadequately equipped to offer transition-related care. As a result, there are a growing number of multidisciplinary clinics with a high level of clinical expertise in TG health care. However, establishing a TG health care program has numerous challenges.

Launching a TG Health Initiative in Dallas

TG Health Care Clinics

TG individuals have the same general life problems and require the same basic preventive and therapeutic health care as non-TG counterparts. In addition, they also have a unique set of mental and physical health care needs related to transition, such as cross-gender hormone therapy. Furthermore, many TG individuals require assistance from a wide range of social services because of high rates of unemployment and homelessness.

According to the National Transgender Discrimination Survey, approximately 20% of TG individuals have been homeless at some time in their lives. Therefore, the preliminary venture into an organized TG health care clinic in Dallas County focused on addressing the health care needs of the homeless TG population. The effort is sponsored by Parkland Health & Hospital System (PHHS), which is "dedicated to the health and well-being of individuals and communities entrusted to our care." Serving the underserved has always been a cornerstone of PHHS, and thus, this effort to reach the homeless TG population fits well with the hospital system's mission. The goal of the PHHS Transgender Clinic is to provide respectful, gender-affirming health care for the trans community.

The initial TG health care clinic began in the fall of 2015 at The Stewpot, which is located in downtown Dallas and is close to

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many homeless shelters, the largest being The Bridge of North Texas. The Stewpot has served the homeless and at-risk individuals for almost half a century and seemed the perfect venue to offer health care services for TG homeless individuals. The services provided at The Stewpot went beyond the usual hormone/transition-related care and also included primary health care, mental health, and financial navigation.

As development of the fledgling clinic at The Stewpot proceeded, word spread among the TG community, and the clinic began to receive requests for appointments from nonhomeless TG patients. To avoid overwhelming the limited resources at The Stewpot, PHHS began to explore setting up a second community clinic in Grand Prairie, a suburb of Dallas, to meet the health care needs of a broader population of TG patients beyond the homeless. Members of the TG community provided valuable input to clinic operations leaders regarding the location of the second clinic and the types of health care services needed. The second PHHS TG clinic is scheduled to open in May, 2016.

An initial goal in setting up the PHHS TG health care clinics was to offer cultural competency training and education for hospital administrative and support staff, physicians, nurses, and the police department. One of the authors of this article, Redfern, conducted the first training session to help office and frontline staff increase their comfort level working with TG clients. The training covered TG culture and its diversity, medical care of TG individuals, TG health care disparities, and improving interaction with TG patients, especially in the intake and assessment setting. The Inclusion and Diversity Branch of Office of Talent Management/Human Resources Department at PHHS subsequently offered LGBT cultural competency training, specifically focused on TG cultural sensitivity. Additional ongoing staff trainings are planned with a more clinical focus on hormone regimens and case studies.

Offering psychological assistance over the long term should be considered a cornerstone of responsible care

Changes to intake forms and electronic medical records (EMRs) are in progress to adequately and sensitively acquire relevant demographic data relevant to TG patients and to ensure that preferred names and pronouns are used consistently. These changes may also enable reminders to practitioners about routine screening procedures such as Pap tests and pelvic exams for TG men, mammography for both TG men and women, and prostate exams and prostate-specific antigen (PSA) testing for TG women.

An additional issue requiring careful consideration pertained to prescribing cross-gender hormone therapy, especially given that testosterone is a controlled substance. Cross-gender hormone therapy administration is not without possible medical consequences, and heated discussions often occurred among practitioners on how best to balance the physician's perspective with the needs of the patient. In general, physicians are not broadly educated on hormone treatment regimens to help TG patients with their transition. Likewise, TG patients are not always cognizant of the potential, sometimes serious, side effects of chronic therapy with testosterone or estrogens, such as thromboembolic disease, polycystic ovarian disease, and hepatic injury. There are certainly clinical situations in which cross-sex hormone therapy is inadvisable if not irresponsible because of the increased health risks it poses.

Before TG individuals receive any gender-affirmation services, including initiation of cross-gender hormone therapy, treatment guidelines typically recommend a period of mental health assessment and a real-life test period, in which TG individuals live full time in their preferred gender role. In contrast, many TG individuals seeking hormone therapy regard these requirements as an irritating and unnecessary barrier, if not a discriminatory practice. An alternative practical solution to bridge this divide is the *informed consent model*, as adopted by the Fenway Institute in Boston, Massachusetts. In this approach, TG patients undergo a hormone readiness assessment and complete an informed consent form but do not undergo extensive mandatory mental health counseling. Our management approach for TG individuals seeking hormone therapy was fashioned on the approach taken by the Tom Waddell Health Center in San Francisco and the Center of Excellence for Transgender Health at the University of California at San Francisco. This approach includes assessment for major preexisting physical and psychiatric issues, but it does not mandate a real-life test period. Nevertheless, offering some kind of psychological assistance over the long term to TG individuals should be considered a cornerstone of responsible care, especially in light of the high suicide rates.

Table 1. *Participating Organizations in the Dallas Transgender Service Providers Collaborative*

Organizations/Providers
• Parkland Health and Hospital System
o Outpatient and ambulatory services
o HIV services
o Nursing services
o Mental health services
o Hospital security/police
• University of Texas Southwestern Medical Center
o Endocrinology
• Trans Pride Initiative and other community organizations
• Dallas-Fort Worth Hospital Council
• Dallas County Health Department
• Local LGBT and HIV health care clinics (e.g., Nelson Tebedo Clinic)
• Metro Dallas Homeless Alliance
• University of North Texas LGBT Research Group
• Private physicians

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In addition to playing a crucial role in the psychological well-being of TG individuals, it is clear that mental health services will also play a pivotal role in the future logistics of providing health care to this group of patients. Because a clinical diagnosis of gender dysphoria is usually a requirement for coverage of transition-related medical services by many public and private medical insurance providers, mental health practitioners have historically served a gatekeeper role in helping TG patients obtain reimbursement. This approach may seem reasonable, logical, and consistent with treatment guidelines issued by numerous professional organizations for gender dysphoria, but many TG people do not see their condition as a psychopathology. Indeed, a mental health diagnosis of gender dysphoria is something that many find demeaning and unacceptable. Thus, a catch-22 exists from a health insurance perspective: recognize gender identity variance as a medical condition that necessitates transition-related health care and insurance coverage, or accept gender identity variance as normal biologic variation and pay out-of-pocket for all transition-related medical services.

A mental health diagnosis of gender dysphoria is something that many find demeaning and unacceptable

Easily accessible yet closely supervised hormone therapy with frequent monitoring for possible side effects is of paramount importance to help prevent some intrepid TG patients from taking a "do-it-yourself" approach to transition and resorting to self-administration of black-market hormones of questionable composition. Anecdotally, there have been instances in which TG patients have gone so far as to intentionally expose themselves to HIV in an attempt to become eligible to attend HIV clinics and receive a prescription for hormones.

TG Service Provider Collaborative

In addition to starting the two TG health care clinics, PHHS also spearheaded the development of a county-wide TG service provider collaborative that involved a variety of local groups and organizations (see Table 1). The aim was to address in a more comprehensive manner the issues facing a large segment of the TG population, including housing, legal services, mental health, medical insurance, and clinical issues.

As the Dallas County TG service provider collaborative began to evolve, it became apparent that a key issue to overcome was the limited or nonexistent communication among the various resource agencies. Lack of coordinating care and assistance among disparate agency resources, all of which had different procedures and processes based on varying models of payment, accessibility, and staffing, makes delivery of services inefficient and time-consuming and is frustrating for patients and providers.

Full implementation and coordination of comprehensive health care services for the TG community in the Dallas area will undoubtedly take time. The need for and the subsequent rollout of the numerous medical, behavioral, and surgical services relevant to transition remain to be fully characterized and addressed. Implementation of these services also needs to be entwined with funding (governmental or corporate sponsorship), reimbursement/insurance coverage (including Medicaid and Medicare, and private medical insurance) for various gender-affirming health care services, education, personnel training, and research in addition to outreach and engagement of TG people in the community. Thus far, PHHS TG health care clinics operate on public funds, but the TG service provider collaborative is currently operating on an unfunded, volunteer basis.

Comprehensive TG-specific health services can also play an important role in helping to address the burgeoning prevalence of HIV among TG people. Some, but certainly by no means all, TG women live on the fringes of society and engage in drug use and sex work, both of which contribute to the high rates of HIV infection in this population. Thus, clinics providing access to feminizing or masculinizing hormones represent a valuable entry point to obtain HIV treatment, particularly for those TG people whose high-risk behaviors make them especially vulnerable to acquiring sexually transmitted diseases (STDs). This health care point of entry may be particularly effective since many TG people assign a higher priority to hormone therapy relative to HIV care and treatment, at least according to the 2015 World Health Organization policy brief on TG people and HIV.

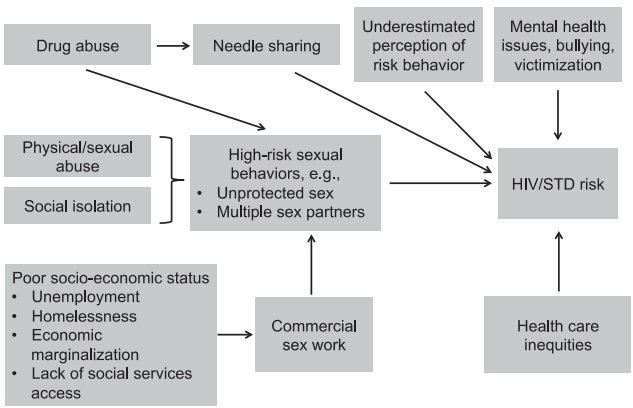

Figure 2. Examples of potential factors influencing risk of HIV/STD infection in TG individuals.

The Burgeoning Prevalence of HIV Among TG People

TG women carry a heavy burden of HIV/AIDS, especially those who have sex with men, and yet these individuals have historically been overlooked in the global response to prevent HIV infection. According to a 2008 meta-analysis by Jeffrey Herbst and colleagues, about 28% of TG women in

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the United States were HIV positive, a figure that is much higher than that seen in the men-having-sex-with-men population. Other STDs besides HIV are similarly highly prevalent among the TG population.

Increased risk of STD/HIV infection among TG women may result from a variety of factors including high-risk sexual behaviors, underestimated perception of risk behavior, mental health issues, and health care inequities (see Figure 2). For some TG women, their psychological mindset may also contribute to an increased vulnerability to HIV infection. TG women may be more likely to have unprotected sex with partners, who themselves are at high risk for HIV infection, in a desire to seek gender affirmation.

Psychosocial Impact of Living With STDs

With respect to HIV infection and AIDS, individuals may experience a number of mental health issues, including adjustment to a diagnosis associated with stigma and discrimination, major depressive disorder, anxiety disorders, potential risk of suicide, substance abuse, and infection-related dementia. For a TG individual who is already experiencing stigma on multiple levels, the added burden of having an STD may cause a ripple effect that may disproportionately and markedly affect their sense of self-worth and quality of life.

Conclusions

The psychological and quality-of-life benefits and necessity of gender transition treatments are widely acknowledged, although the robustness of the collective evidence base is attenuated by significant methodological limitations. Much remains to be learned about the long-term ramifications of gender-affirmation therapeutic interventions, particularly with respect to the alarmingly high rates of suicide. How can we do a better job at helping TG individuals to critically assess whether transition is best for them in the long term, to handle negativity without derailment, to elevate a sense of self-worth, and to address any feelings of shame or self-loathing? Providing TG-specific health care services, in particular, may help to address the burgeoning prevalence of HIV among TG people. However, accessing gender-affirming medical care and other social services remains a challenge for many TG individuals. One approach to address this shortfall in the Dallas area has been the creation of TG health care clinics run by PHHS and a TG service provider collaborative. Lessons learned from setting up the TG health care clinics include: the necessity of cultural competency training for all staff, the importance of collaboration with the TG community to identify key health care needs and how best to deliver services, and the urgent need for legislative advocacy to solidify and clarify insurance coverage for TG-related health care services.

Keywords: transgender; health care; sexually transmitted diseases; outcomes; psychosocial factors

Suggestions for Further Reading

American Psychiatric Association. (2013). Gender dysphoria. *In Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: American Psychiatric Publishing. Retrieved from http://www.dsm5.org/documents/gender%20dysphoria%20fact%20sheet.pdf

Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., . . . Zucker, K. (2011). Standards of care for the health of transsexual, transgender, and gender-nonconforming people, Version 7. *International Journal of Transgenderism, 13,* 165–232. http://dx.doi.org/10.1080/15532739.2011.700873

Cruz, T. M. (2014). Assessing access to care for transgender and gender nonconforming people: A consideration of diversity in combating discrimination. *Social Science & Medicine, 110,* 65–73.

de Vries, A. L., McGuire, J. K., Steensma, T. D., Wagenaar, E. C., Doreleijers, T. A., & Cohen-Kettenis, P. T. (2014). Young adult psychological outcome after puberty suppression and gender reassignment. *Pediatrics, 134,* 696–704.

Dhejne, C., Lichtenstein, P., Boman, M., Johansson, A. L., Långström, N., & Landén, M. (2011). Long-term follow-up of transsexual persons undergoing sex reassignment surgery: Cohort study in Sweden. *PLoS ONE 6*(2), e16885. http://dx.doi.org/10.1371/journal.pone.0016885

Grant, J. M., Mottet, L. A., Tanis, J., Harrison, J., Herman, J. L., & Keisling, M. (2011). *Injustice at every turn. A report of the National Transgender Discrimination Survey*. Retrieved from the National Gay and Lesbian Task Force website: http://ww.thetaskforce.org

Herbst, J. H., Jacobs, E. D., Finlayson, T. J., McKleroy, V. S., Neumann, M. S., Crepaz, N., & HIV/AIDS Prevention Research Synthesis Team. (2008). Estimating HIV prevalence and risk behaviors of transgender persons in the United States: a systematic review. *AIDS and Behavior, 12,* 1–17.

Murad, M. H., Elamin, M. B., Garcia, M. Z., Mullan, R. J., Murad, A., Erwin, P. J., & Montori, V. M. (2010). Hormonal therapy and sex reassignment: A systematic review and meta-analysis of quality of life and psychosocial outcomes. *Clinical Endocrinology, 72,* 214–231.

Nadal, K. L., Skolnik, A., & Wong, Y. (2012). Interpersonal and systemic microaggressions toward transgender people: Implications for Counseling. *Journal of LGBT Issues in Counseling, 6,* 55–82.

Perez-Brumer, A., Hatzenbuehler, M. L., Oldenburg, C. E., & Bockting, W. (2015). Individual- and structural-level risk factors for suicide attempts among transgender adults. *Behavioral Medicine, 41,* 164–171.

Redfern, J. S., & Sinclair, B. (2014) Improving health care encounters and communication with transgender patients. *Journal of Communication in Healthcare: Strategies, Media and Engagement in Global Health, 7,* 25–40. http://dx.doi.org/10.1179/1753807614Y.0000000045

World Health Organization. (2015). *Policy brief: Transgender people and HIV*. Geneva, Switzerland: Author. Retrieved from http://apps.who.int/iris/bitstream/10665/179517/1/WHO_HIV_2015.17_eng.pdf?ua=1&ua=1

(*Appendix follows*)

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Appendix

Definitions of Terms

Terms used in this article are based, in part, on the *DSM-5* Gender Dysphoria Fact Sheet and on Coleman et al. (2011).

Gender-affirmation surgery (sex-reassignment surgery): Surgery to change primary and/or secondary sex characteristics to affirm a person's gender identity.

Gender dysphoria (formerly gender identity disorder): Formal diagnosis presented in the *Diagnostic Statistical Manual of Mental Disorders, 5th Edition (DSM-5)*. Individuals with a marked difference between expressed/experienced gender and the gender others would assign him or her. Gender dysphoria is manifested by a strong desire to be treated as the other gender or to be rid of one's sex characteristics, or a strong conviction that one has feelings and reactions typical of the other gender. The condition causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Gender identity: Intrinsic sense of being male, female, or alternative gender (e.g., boygirl, genderqueer).

Transgender (TG): A diverse group of individuals who cross or transcend cultural expectations and assumptions regarding gender. The gender identity of TG people differs to varying degrees from the sex assigned at birth. TG people may or may not desire hormones or surgery to alter their bodies. The term TG includes transsexuals, intersex persons, and individuals whose gender identity falls outside of the stereotypical male/female gender binary.

Transsexual (term used in older medical and psychological literature): Individuals whose gender identity differs from the sex assigned at birth and who seek to change or who have changed their primary and/or secondary sex characteristics through feminizing or masculinizing medical interventions (hormones and/or surgery), typically accompanied by a permanent change in gender role.

TG or *trans man* (female to male): Individuals who were assigned female at birth and who are changing or who have changed their body and/or gender role from birth-assigned female to a more masculine body or role.

TG or *trans woman* (male to female): Individuals who were assigned male at birth and who are changing or who have changed their body and/or gender role from birth-assigned male to a more feminine body or role.

Transphobia: Hatred or fear of TG and gender-nonconforming people.

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